

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-033677

STATE FILE NUMBER

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8328

FILED AUG 22 1963

DO NOT WRITE
ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION
BY AFFIDAVIT OF

USE BLACK INK
OR
TYPEWRITER RIBBON

1. PLACE OF DEATH a. COUNTY Missouri		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY St. Louis	
b. CITY (If outside corporate limits, give TOWNSHIP only) St. Louis		c. CITY OR TOWN St. Louis	
c. FULL NAME OF (If NOT in hospital, give location) Firmin Desloge Hosp.		d. STREET ADDRESS 4966 Thekla Avenue	
3. NAME OF DECEASED (Type or print) FRANCES GRONEFELD		4. DATE OF DEATH Month Aug. Day 18, Year 1963	
5. SEX female	6. COLOR OR RACE white	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH July 1, 1882
9. AGE (last birthday) 81	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) restaurant owner (ret)		11. BIRTHPLACE (City and state or country) Lynn, Missouri
12. CITIZEN OF WHAT COUNTRY USA		13. NAME OF HUSBAND OR WIFE deceased	
13a. FATHER'S NAME Frank Adrain		14. MOTHER'S MAIDEN NAME Elizabeth Tweehouse	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. 722.0	
17. INFORMANT Edward Adrain 3109 Wolter		18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Splenic Abscess DUE TO (b) Felty's Syndrome DUE TO (c) 722.0	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I. (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour 7:15 a.m. 7:15 p.m.	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION St. Louis, Missouri
21. I attended the deceased from 3/28/62 to 8/13/63 and last saw her alive on 8/13/63 Death occurred at 7:15 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22a. SIGNATURE George M. Jankovic, M.D.	
22b. ADDRESS 8818 Garrio		22c. DATE SIGNED 8/15/63	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 8/17/1963	23c. NAME OF CEMETERY OR CREMATORY Calvary Cemetery	23d. LOCATION (City, town, or county) St. Louis, Missouri
24. FUNERAL DIRECTOR Bromschwig and Son	25. DATE RECD. BY LOCAL REG. AUG 16 1963	26. REGISTRAR'S SIGNATURE Roald Smith, M.D.	

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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Harvey Kahle

Licensed Embalmer No. 4596

P. O. Address St Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.

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